Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005056	A. BUILDING _____ B. WING _____	R 10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL	1314 E WALNUT ST WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS This visit was for the follow-up investigation of one (1) State complaint. Complaint number: IN00087028 Date of survey: 10-2-12 Facility number: 005056 Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Daviess Community Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules. QA: claughlin 10/30/12	{S 000}		